Prepared by John Nakashima, Ph.D., MSW
Program Analyst, Community Care, VA Greater Los Angeles HCS

CHALENG 2005 Survey: VA Greater Los Angeles HCS (VAOPC Los Angeles - 691GE and VAMC Sepulveda - 691A4 and VAMC West Los Angeles - 691)

A. Homeless Veteran Estimates:

1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 21424

2. Estimated Number of Veterans who are Chronically Homeless: 5356

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 21424 (estimated number of homeless veterans in service area) **x chronically homeless rate (25 %)** (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	1000	0
Transitional Housing Beds	1200	500
Permanent Housing Beds	70	1500

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: 107

3. CHALENG Point of Contact Action Plan for FY 2005

Long-term, permanent housing	Pursue new New Directions Permanent Housing project on VA Sepulveda campus.
Treatment for dual diagnosis	Encourage VA Grant and Per Diem providers to develop dual diagnosis programs. Continue working with dual diagnosis clients in Collaborative Initiative to Help End Chronic Homelessness "Housing First" Program.
Job training	New supported employment program will place many veterans with severe mental illness into jobs.

C. Data from the CHALENG Participant Survey

Number of Participant Surveys: **99 Non-VA staff Participants: 70.7%**
Homeless/Formerly Homeless: **19.2%**

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Need	Site Mean Score	*% want to work on this need now	VHA Mean** Score (all VA sites)
Personal hygiene	3.55	6.0%	3.47
Food	3.78	7.0%	3.80
Clothing	3.42	5.0%	3.61
Emergency (immediate) shelter	3.33	20.0%	3.33
Halfway house or transitional living facility	3.52	16.0%	3.07
Long-term, permanent housing	2.58	45.0%	2.49
Detoxification from substances	3.52	6.0%	3.41
Treatment for substance abuse	3.84	10.0%	3.55
Services for emotional or psychiatric problems	3.5	12.0%	3.46
Treatment for dual diagnosis	3.3	20.0%	3.30
Family counseling	2.86	1.0%	2.99
Medical services	3.99	3.0%	3.78
Women's health care	3.28	12.0%	3.23
Help with medication	3.52	.0%	3.46
Drop-in center or day program	3.33	1.0%	2.98
AIDS/HIV testing/counseling	3.66	1.0%	3.51
TB testing	3.98	.0%	3.71
TB treatment	3.78	.0%	3.57
Hepatitis C testing	3.82	.0%	3.63
Dental care	2.80	24.0%	2.59
Eye care	3.00	7.0%	2.88
Glasses	3.02	9.0%	2.88
VA disability/pension	3.30	8.0%	3.40
Welfare payments	3.29	.0%	3.03
SSI/SSD process	3.29	6.0%	3.10
Guardianship (financial)	2.88	2.0%	2.85
Help managing money	2.96	5.0%	2.87
Job training	3.12	12.0%	3.02
Help with finding a job or getting employment	3.31	17.0%	3.14
Help getting needed documents or identification	3.37	2.0%	3.28
Help with transportation	3.28	1.0%	3.02
Education	3.15	7.0%	3.00
Child care	2.46	2.0%	2.45
Legal assistance	2.86	10.0%	2.71
Discharge upgrade	2.97	1.0%	3.00
Spiritual	3.31	3.0%	3.36
Re-entry services for incarcerated veterans	3.17	8.0%	2.72
Elder Healthcare	3.08	9.0%	3.06

*** % of site participants who identified this need as one of the top three they would like to work on now.**
****VHA: Veterans Healthcare Administration (136 reporting POC sites, n=4321).**

2. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site Mean Score (non-VA respondents only)**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.90
Co-location of Services - Services from the VA and your agency provided in one location.	2.44
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2.21
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.69
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.92
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	2.03
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	2.23
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.45
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	2.33
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.89
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.87
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	2.05

3. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	**Site Mean Score (non-VA respondents only)**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.86
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.89

Prepared by John Nakashima, Ph.D., MSW
Program Analyst, Community Care, VA Greater Los Angeles HCS

CHALENG 2005 Survey: VA Southern Nevada HCS - 593

A. Homeless Veteran Estimates:

1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 4300

2. Estimated Number of Veterans who are Chronically Homeless: 688

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 4300 (estimated number of homeless veterans in service area) **x chronically homeless rate (16 %)** (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	43	200
Transitional Housing Beds	193	100
Permanent Housing Beds	122	75

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: 8

3. CHALENG Point of Contact Action Plan for FY 2005

Immediate shelter	Improve relationship with LV Neighborhood Services to gain access to immediate shelter. Continue relationship with sites that are already providing shelter to request "set-aside" beds for veterans. Maintain involvement with HUD Continuum of Care.
Transitional living facility or halfway house	Continue to work with community partners to apply for VA Grant and Per Diem funds. Increase focus on smaller groups/organizations that show interest in "special" veteran populations (seniors, ex-felons, chronically mentally ill).
Long-term, permanent housing	Explore community housing/individuals that express interest in housing veterans. Provide educational information to individual landlords who express interest in providing permanent housing to single veterans.

C. Data from the CHALENG Participant Survey

Number of Participant Surveys: **84** **Non-VA staff Participants: 82.9%**
Homeless/Formerly Homeless: **21.4%**

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Need	Site Mean Score	*% want to work on this need now	VHA Mean** Score (all VA sites)
Personal hygiene	3.03	2.0%	3.47
Food	3.03	15.0%	3.80
Clothing	3.13	3.0%	3.61
Emergency (immediate) shelter	2.84	33.0%	3.33
Halfway house or transitional living facility	3.03	23.0%	3.07
Long-term, permanent housing	2.50	40.0%	2.49
Detoxification from substances	2.58	17.0%	3.41
Treatment for substance abuse	2.73	13.0%	3.55
Services for emotional or psychiatric problems	2.8	7.0%	3.46
Treatment for dual diagnosis	2.7	3.0%	3.30
Family counseling	2.61	.0%	2.99
Medical services	3.13	10.0%	3.78
Women's health care	2.81	.0%	3.23
Help with medication	3.04	2.0%	3.46
Drop-in center or day program	2.47	13.0%	2.98
AIDS/HIV testing/counseling	2.85	.0%	3.51
TB testing	3.46	2.0%	3.71
TB treatment	3.10	.0%	3.57
Hepatitis C testing	3.13	.0%	3.63
Dental care	2.21	21.0%	2.59
Eye care	2.27	11.0%	2.88
Glasses	2.15	3.0%	2.88
VA disability/pension	2.88	12.0%	3.40
Welfare payments	2.46	2.0%	3.03
SSI/SSD process	2.57	5.0%	3.10
Guardianship (financial)	2.70	2.0%	2.85
Help managing money	2.72	5.0%	2.87
Job training	2.72	8.0%	3.02
Help with finding a job or getting employment	2.92	8.0%	3.14
Help getting needed documents or identification	3.04	13.0%	3.28
Help with transportation	2.76	10.0%	3.02
Education	2.64	2.0%	3.00
Child care	2.07	.0%	2.45
Legal assistance	2.41	10.0%	2.71
Discharge upgrade	2.68	.0%	3.00
Spiritual	2.73	.0%	3.36
Re-entry services for incarcerated veterans	2.22	3.0%	2.72
Elder Healthcare	2.57	3.0%	3.06

*** % of site participants who identified this need as one of the top three they would like to work on now.**
****VHA: Veterans Healthcare Administration (136 reporting POC sites, n=4321).**

2. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site Mean Score (non-VA respondents only)**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.72
Co-location of Services - Services from the VA and your agency provided in one location.	1.89
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2.07
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.50
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.64
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.84
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	2.09
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.33
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	2.00
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.84
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	2.14
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.90

3. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	**Site Mean Score (non-VA respondents only)**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.27
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.61

Prepared by John Nakashima, Ph.D., MSW
Program Analyst, Community Care, VA Greater Los Angeles HCS

CHALENG 2005 Survey: VAMC Loma Linda, CA - 605

A. Homeless Veteran Estimates:

1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 8000

2. Estimated Number of Veterans who are Chronically Homeless: 1200

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 8000 (estimated number of homeless veterans in service area) **x chronically homeless rate (15 %)** (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	200	300
Transitional Housing Beds	126	200
Permanent Housing Beds	0	500

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: 25

3. CHALENG Point of Contact Action Plan for FY 2005

Help finding a job or getting employment	Reconnect with San Bernardino County Economic Development Agency. Continue to work with Riverside County EDA.
Long-term, permanent housing	This has been and continues to be an on-going problem. We are making renewed attempts to work with both Riverside and San Bernardino Counties.
Job training	During the past year, Riverside County's Economic Development Agency lost their state funding for their job training program. We are hopeful it will be re-instated. Attempts are being made to reconnect with San Bernardino County's EDA.

C. Data from the CHALENG Participant Survey

Number of Participant Surveys: **10 Non-VA staff Participants: 50.0%**
Homeless/Formerly Homeless: **80.0%**

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Need	Site Mean Score	*% want to work on this need now	VHA Mean** Score (all VA sites)
Personal hygiene	4.44	.0%	3.47
Food	4.22	14.0%	3.80
Clothing	4.33	14.0%	3.61
Emergency (immediate) shelter	4.44	.0%	3.33
Halfway house or transitional living facility	4.29	.0%	3.07
Long-term, permanent housing	3.57	29.0%	2.49
Detoxification from substances	4.38	.0%	3.41
Treatment for substance abuse	4.56	29.0%	3.55
Services for emotional or psychiatric problems	3.3	.0%	3.46
Treatment for dual diagnosis	3.4	.0%	3.30
Family counseling	2.86	14.0%	2.99
Medical services	4.22	14.0%	3.78
Women's health care	3.00	.0%	3.23
Help with medication	4.14	14.0%	3.46
Drop-in center or day program	3.00	.0%	2.98
AIDS/HIV testing/counseling	4.00	.0%	3.51
TB testing	4.67	.0%	3.71
TB treatment	3.17	.0%	3.57
Hepatitis C testing	4.00	14.0%	3.63
Dental care	3.11	.0%	2.59
Eye care	2.88	.0%	2.88
Glasses	2.88	.0%	2.88
VA disability/pension	2.86	14.0%	3.40
Welfare payments	2.57	.0%	3.03
SSI/SSD process	3.57	14.0%	3.10
Guardianship (financial)	2.67	14.0%	2.85
Help managing money	2.83	14.0%	2.87
Job training	3.33	14.0%	3.02
Help with finding a job or getting employment	3.67	43.0%	3.14
Help getting needed documents or identification	4.33	14.0%	3.28
Help with transportation	4.00	14.0%	3.02
Education	2.83	.0%	3.00
Child care	2.50	.0%	2.45
Legal assistance	3.13	.0%	2.71
Discharge upgrade	3.00	.0%	3.00
Spiritual	4.00	.0%	3.36
Re-entry services for incarcerated veterans	3.71	14.0%	2.72
Elder Healthcare	3.00	.0%	3.06

*** % of site participants who identified this need as one of the top three they would like to work on now.**
****VHA: Veterans Healthcare Administration (136 reporting POC sites, n=4321).**

2. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site Mean Score (non-VA respondents only)**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	3.00
Co-location of Services - Services from the VA and your agency provided in one location.	1.00
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2.00
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.00
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.00
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.00
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	2.00
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.00
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	2.00
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.00
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.00
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	2.00

3. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	**Site Mean Score (non-VA respondents only)**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	4.50
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	4.00

Prepared by John Nakashima, Ph.D., MSW
Program Analyst, Community Care, VA Greater Los Angeles HCS

CHALENG 2005 Survey: VAMC Long Beach, CA - 600

A. Homeless Veteran Estimates:

1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 21424*

2. Estimated Number of Veterans who are Chronically Homeless: 5356

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 21424* (estimated number of homeless veterans in service area) **x chronically homeless rate (24 %)** (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	700	200
Transitional Housing Beds	832	70
Permanent Housing Beds	550	100

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: 4

3. CHALENG Point of Contact Action Plan for FY 2005

Immediate shelter	Establish cooperative agreements with sever temporary housing providers. Identify points of contact at temporary shelters to more efficiently place at point of need. Explore long-term facility upgrade issues and funding sources for domiciliary.
Long-term, permanent housing	Develop stronger relationship with Section 8 housing to improve advocacy, information share and utilize housing support options when available. Increase utilization of home-loan opportunities to assist individuals eligible and interested.
Dental care	Develop network of loc-cost dental resources to improve utilization. Promote network of community dental providers willing to explore donated dental to veterans ineligible for VA dental.

C. Data from the CHALENG Participant Survey

Number of Participant Surveys: **47 Non-VA staff Participants: 93.5%**
Homeless/Formerly Homeless: **10.6%**

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Need	Site Mean Score	*% want to work on this need now	VHA Mean** Score (all VA sites)
Personal hygiene	2.76	5.0%	3.47
Food	3.17	3.0%	3.80
Clothing	3.13	3.0%	3.61
Emergency (immediate) shelter	2.38	34.0%	3.33
Halfway house or transitional living facility	2.45	27.0%	3.07
Long-term, permanent housing	1.85	61.0%	2.49
Detoxification from substances	2.82	14.0%	3.41
Treatment for substance abuse	3.15	14.0%	3.55
Services for emotional or psychiatric problems	2.8	16.0%	3.46
Treatment for dual diagnosis	2.8	8.0%	3.30
Family counseling	2.33	3.0%	2.99
Medical services	3.25	3.0%	3.78
Women's health care	2.79	8.0%	3.23
Help with medication	2.80	3.0%	3.46
Drop-in center or day program	2.62	3.0%	2.98
AIDS/HIV testing/counseling	2.95	.0%	3.51
TB testing	3.13	.0%	3.71
TB treatment	2.85	.0%	3.57
Hepatitis C testing	3.10	3.0%	3.63
Dental care	1.95	16.0%	2.59
Eye care	2.23	3.0%	2.88
Glasses	2.26	.0%	2.88
VA disability/pension	3.03	5.0%	3.40
Welfare payments	3.03	3.0%	3.03
SSI/SSD process	2.84	.0%	3.10
Guardianship (financial)	2.66	.0%	2.85
Help managing money	2.50	3.0%	2.87
Job training	2.83	13.0%	3.02
Help with finding a job or getting employment	3.07	8.0%	3.14
Help getting needed documents or identification	2.90	.0%	3.28
Help with transportation	2.63	16.0%	3.02
Education	2.82	3.0%	3.00
Child care	2.34	8.0%	2.45
Legal assistance	2.79	.0%	2.71
Discharge upgrade	2.89	.0%	3.00
Spiritual	3.18	5.0%	3.36
Re-entry services for incarcerated veterans	2.65	14.0%	2.72
Elder Healthcare	2.67	8.0%	3.06

*** % of site participants who identified this need as one of the top three they would like to work on now.**
****VHA: Veterans Healthcare Administration (136 reporting POC sites, n=4321).**

2. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site Mean Score (non-VA respondents only)**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.29
Co-location of Services - Services from the VA and your agency provided in one location.	1.63
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	1.51
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	1.97
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.46
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.44
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.64
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.00
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.92
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.38
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.49
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.54

3. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	**Site Mean Score (non-VA respondents only)**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.21
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.23

Prepared by John Nakashima, Ph.D., MSW
Program Analyst, Community Care, VA Greater Los Angeles HCS

CHALENG 2005 Survey: VAMC San Diego, CA - 664

A. Homeless Veteran Estimates:

1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 2000

2. Estimated Number of Veterans who are Chronically Homeless: 760

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 2000 (estimated number of homeless veterans in service area) **x chronically homeless rate (38 %)** (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	1076	320
Transitional Housing Beds	1260	10
Permanent Housing Beds	707	600

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: 25

3. CHALENG Point of Contact Action Plan for FY 2005

Long-term, permanent housing	Continue to monitor the program and advocate for the construction of five California Veteran homes. Currently estimated to open in 2008-09.
Immediate shelter	Advocate for increased bed access at St. Vincent De Paul emergency shelter. Expand informal or formal shelter agreements with other community providers.
Dental care	Continue to utilize VHA Dental Directive Program.

C. Data from the CHALENG Participant Survey

Number of Participant Surveys: **39** **Non-VA staff Participants: 71.4%**
Homeless/Formerly Homeless: **20.5%**

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Need	Site Mean Score	*% want to work on this need now	VHA Mean** Score (all VA sites)
Personal hygiene	3.41	8.0%	3.47
Food	3.54	3.0%	3.80
Clothing	3.44	3.0%	3.61
Emergency (immediate) shelter	2.13	53.0%	3.33
Halfway house or transitional living facility	2.64	26.0%	3.07
Long-term, permanent housing	2.11	42.0%	2.49
Detoxification from substances	2.95	16.0%	3.41
Treatment for substance abuse	3.41	5.0%	3.55
Services for emotional or psychiatric problems	3.4	16.0%	3.46
Treatment for dual diagnosis	3.2	11.0%	3.30
Family counseling	2.85	5.0%	2.99
Medical services	3.62	5.0%	3.78
Women's health care	3.31	3.0%	3.23
Help with medication	3.38	.0%	3.46
Drop-in center or day program	2.97	3.0%	2.98
AIDS/HIV testing/counseling	3.72	.0%	3.51
TB testing	3.74	3.0%	3.71
TB treatment	3.69	.0%	3.57
Hepatitis C testing	3.58	3.0%	3.63
Dental care	2.61	8.0%	2.59
Eye care	2.79	5.0%	2.88
Glasses	2.61	5.0%	2.88
VA disability/pension	3.68	8.0%	3.40
Welfare payments	3.25	.0%	3.03
SSI/SSD process	3.33	8.0%	3.10
Guardianship (financial)	2.97	3.0%	2.85
Help managing money	2.79	.0%	2.87
Job training	3.21	16.0%	3.02
Help with finding a job or getting employment	3.38	13.0%	3.14
Help getting needed documents or identification	3.29	3.0%	3.28
Help with transportation	3.03	3.0%	3.02
Education	3.15	5.0%	3.00
Child care	2.42	5.0%	2.45
Legal assistance	2.87	3.0%	2.71
Discharge upgrade	3.14	.0%	3.00
Spiritual	3.23	.0%	3.36
Re-entry services for incarcerated veterans	2.82	11.0%	2.72
Elder Healthcare	3.00	.0%	3.06

*** % of site participants who identified this need as one of the top three they would like to work on now.**
****VHA: Veterans Healthcare Administration (136 reporting POC sites, n=4321).**

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Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2.38
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	3.08
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.87
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	2.04
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	2.09
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.74
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	2.57
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	2.13
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	2.22
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	2.30

3. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	**Site Mean Score (non-VA respondents only)**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.71
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.87